NEW PATIENT REGISTRATION

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Contact Information		
First Name Last Name Daytime Phone Mobile Phone Email	Street Address Suite/Apt. City State Zip Code	
Guardian Information (if patient is under 18 years of age)		
First Name Last Name Daytime Phone Mobile Phone Email	Street Address Suite/Apt. City State Zip Code	
Patient Information	Primary Insurance Information	
Gender Date of Birth Social Security No.	Provider Name Provider Phone Policy/I.D. No. Group No.	
Secondary Insurance Information	Additional Insurance Information	
Provider Name Provider Phone Policy/I.D. No. Group No.	Provider Name Provider Phone Policy/I.D. No. Group No.	
Financial Assignment Information	Acknowledgment of Notice of Privacy Practices (NPP)	
I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.	Yes, I have read or had explained to me by this office the NPP & I wish to continue my care under said terms. No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms. The NPP could not be read due to the emergent nature of the care needed.	
Signature agreeing to all above terms	Date	

PATIENT HISTORY

Vision Correction History (please check any that apply) Amblyopia (lazy eye) Fluctuating vision Loss of vision Blurred vision at a distance Foreign body sensation Mucous discharge Blurred vision at near Halos Redness Burning I experience regular headaches Sandy or gritty feeling Double vision I stopped wearing contact lenses Sensitivity to light/glare Drooping eyelid(s) Strabismus (crossed eye) I stopped wearing glasses Dryness Infection of eye or lid Tired eyes Eye pain and/or soreness Itching Watery eyes Floaters or spots Loss of peripheral vision

Glasses History (check all that apply)					
What glasses do you own?		Check any that apply			
Backup pair	Safety glasses	Allergic to nickel (frames)			
Bifocals	Single vision	I do not want to wear glasses			
Distance	Sports glasses	Incorrect prescription			
Progressive lens	Sunglasses	Need spare glasses			
Reading	Trifocals	Need sunglasses with UV			
Other:		Problems with current glasses			
		Problems with glare			
How many hours per day do you	spend using a computer?	Problems with night vision			

Contact Lens History (check all that apply)	
What brand of contacts do you wear?	Check any that apply
How old are your current contacts?	I do not want to wear contacts
How often do you replace them?	Incorrect prescription
What solution do you use for soaking?	Interested in non-surgical correction
What is your typical wearing schedule?	Interested in refractive laser surgery
	Need spare contacts
	Problems with current contacts
	Would like to change my eye color

Family History (check all that apply)		Allergies (please list)
Blindness Diabetes	Hypertension Magular degeneration	None
Eye turn/lazy eye	Macular degeneration	
Glaucoma		

PATIENT HISTORY

General Medical History (please answer appropriately)						
When (approx.) was your last eye exam? Primary care physician name Primary care physician phone Please list all eye conditions you have experience	ed:	Do you have any of th Arthritis Asthma Cancer Diabetes	ne following?			
Surgeries:		Heart disease High cholesterol HIV Hypertension (high blood pressure) Migraines/headaches Multiple sclerosis (MS) Other:				
Referral Information						
Why did you visit us? Referred by your doctor Visited our website	Found us on social media Referred directly		Keep in touch Facebook email @Twitter handle			
Questions and notes	Questions and notes					
Do you have a question? Concern? We want	t to know.					